

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

██████████

Petitioner,

v

File No. 145679-001-SF

██

Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 28th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On January 7, 2015, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006, (Act 495) MCL 550.1951 *et seq.* After a preliminary review of the request, the Director accepted it on January 14, 2015.

The Petitioner is enrolled for health care benefits through the ██████████ Health Insurance Pool (the plan), a self-funded public employer pooled plan that is subject to Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. The Director notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Commissioner received BCBSM's response on January 26, 2015.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

I. FACTUAL BACKGROUND

The terms of the Petitioner's health care coverage are contained in the plan's *Member Handbook for Employees of Western Michigan Health Insurance Pool*¹ (the handbook).

From August 26 through October 9, 2014, the Petitioner had acupuncture treatment. The amount charged for the six visits was \$420.00. Because the provider did not participate with BCBSM, the Petitioner submitted claims in order to be reimbursed.

BCBSM's approved amount for the acupuncture treatment was \$336.55 and it paid that amount to the Petitioner. This left the Petitioner responsible for the balance of \$83.45, the difference between the provider's charge and BCBSM's approved amount.

The Petitioner appealed BCBSM's payment amount through the plan's internal grievance process. At the conclusion of that process BCBSM issued a final adverse determination letter dated December 19, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's acupuncture treatment?

IV. ANALYSIS

Petitioner's Argument

The Petitioner says he was told by BCBSM that there were no participating acupuncture providers in the area where he lives and he says he was "instructed that I could go to any acupuncturist and it would be paid 100%."

The Petitioner was charged \$70.00 for each of his six acupuncture visits but BCBSM only paid \$53.31 for each visit.² The Petitioner believes that BCBSM should pay the full amount charged by the provider because of the length of time for each of the visits. The Petitioner also said that he has received full reimbursement for four other claims that were for the same acupuncture treatment.

BCBSM's Argument

In its final adverse determination, BCBSM explained to the Petitioner:

You are covered by the *Western Michigan Health Insurance Pool*. Its *Member*

¹ Revised 03-11-14.

² BCBSM says the September 23, 2014, visit was paid at \$70.00 in error.

Handbook for Employees of [REDACTED] Insurance Pool explains on Page 46 of Section 5; Your Health care Benefits that your benefits cover acupuncture.

The services in question were rendered by [REDACTED]. This provider does not participate with [BCBSM]. Page 13 of Section 3: Selecting a Health Care Provider of the Handbook explains nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services. You are responsible for the amount the provider charged above the BCBS approved amount.

In this case, the claims were processed based upon the receipts submitted which indicates a single charge amount of \$70.00. It has been confirmed with [REDACTED] office manager that the rendering acupuncturists only identify the visit as a single unit of service with a charge of \$70.00. They do not document amounts of time for the rendered services.

In your letter you indicated the charge amount of \$70.00 was for procedure code 97810 (acupuncture, one or more needles; without electrical stimulation, initial 15 minutes of personal direct one-on-one contact with the patient) and 97811 (acupuncture, one or more needles ; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles). Although the services were provided by a nonparticipating provider, the provider still needs to provide you with an itemized statement with the correct current procedural terminology (CPT) or procedure codes detailing the services rendered with a breakdown of the charges. The receipts submitted for reimbursement indicate a single service charge of \$70.00 for acupuncture. Therefore, BCBSM will provide reimbursement only for procedure code 97810 in the amount of \$53.31.

Page 17 of Section 4: Making Most of Your Health care plan of the *Handbook* explains, your coverage consists of services and supplies for which BCBS agrees to pay under the terms of your employer's coverage documents. Payable services and supplies are called "benefits" and are listed in your employer's coverage documents. The payment amount for these benefits is called the "approved amount." This is the BCBS maximum payment level allowed for covered services.

Our reimbursement of \$213.24 was issued to you on December 2, 2014 for the service dates of August 26, September 4, September 11 and October 9, 2014 and our reimbursement of \$53.31 was issued to you on October 16, 2014 for the service date of September 18, 2014. This is the maximum payment level allowed for the services rendered. Thus no additional payment is warranted.

Additionally, the claim for the service date of September 23, 2014 processed incorrectly and BCBSM issued reimbursement in the amount of \$70 to you on October 16, 2014 for procedure codes 97810 and 97811. However, as indicated above this is incorrect. Payment will not be recalled at this time.

You further indicated in your letter that you were advised by a BCBSM customer service representative that the acupuncture services would be covered at 100 percent. As you were previously advised in my August 4, 2014 letter, I reviewed the records of your calls to customer service and confirmed on January 3, 2014 you were advised BCBSM will pay 100 percent of the approved amount for your acupuncture. Again, the claims were paid at 100 percent of the approved amount.

BCBSM believes that it correctly processed the Petitioner's acupuncture claims.

Director's Review

It is undisputed that the Petitioner's acupuncture is a benefit under the plan. The issue here is how much BCBSM is required to reimburse the Petitioner for those services.

The provider in this case is nonparticipating and did not submit claims directly to BCBSM. Instead, the Petitioner paid the provider and then submitted claims to BCBSM along bills that documented the services. However, the provider bills identified the acupuncture service as CPT code 99999, an invalid code. There are valid CPT codes for acupuncture, including 97810 and 97811, the ones that the Petitioner believes correctly identify the services he received.

After BCBSM reviewed the information submitted by the Petitioner and contacted the provider, it concluded that the appropriate procedure code was 97810. BCBSM's approved amount for that procedure is \$53.31 and BCBSM paid 100% of its approved amount for the acupuncture treatments.³ The provider's failure to properly document the nature of the services does not require BCBSM to make a different decision about reimbursing the Petitioner when he submitted the claims.

The handbook (p. 13) also explains that plan members may incur greater out-of-pocket costs when services are received from a nonparticipating provider:

Non-Participating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services.

If your present providers do not participate with BCBS, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, coinsurances and copayments required by your plan along with charges for non-covered services.

You are usually required to pay non-participating providers directly and then you will submit the claim to BCBS for reimbursement. Remember, the amount BCBS

³ As noted above, BCBSM paid \$70.00 for the visit on September 23, 2014.

reimburses you may be less than the amount your provider charged. You are responsible for the amount the provider charged above the BCBS approved amount. [Underlining added]

Because the acupuncture provider is nonparticipating, it may look to the Petitioner for the amount of its charge that exceeds BCBSM's approved amount. The Director found nothing in the handbook that requires the plan to pay more than BCBSM's approved amount even if, as the Petitioner says, there were no participating acupuncturists in his area.

The Petitioner also says that BCBSM told him it would pay 100% of the charge for his acupuncture. BCBSM disputes that assertion, saying it told the Petitioner that it would "pay 100 percent of the approved amount for your acupuncture." Even if the Petitioner's contention is true, the Director has no authority under the Patient's Right to Independent Review Act to alter the provisions of a health care plan because of oral statements made by the employees of the plan or its administrator. The Director can only determine if BCBSM, acting for the plan, correctly administered benefits according to the plan's terms and conditions.

The Director concludes and finds that BCBSM appropriately processed the claims for the Petitioner's acupuncture treatment under the circumstances.

V. ORDER

BCBSM's final adverse determination of December 19, 2014, is upheld. The plan is not required to pay an additional amount for the Petitioner's acupuncture services from a nonparticipating provider.

This is a final decision of an administrative agency. Any person aggrieved by this order may seek judicial review no later than sixty days from the date of this order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director